Attachment I

STATE OF CALIFORNIA
ACKNOWLEDGMENT OF RECEIPT

TO: **Departmental Employee**

SUBJECT: **Acknowledgement of Receipt of the Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility (e3301)**

Attached is a *Workers' Compensation Claim Form & Notice of Potential Eligibility*. Your supervisor or manager is required to provide this form to you within one working day of receiving notification of a potential work-related injury or illness.

When you receive the DWC-1, complete this form and return it to your supervisor or manager.

You must complete the DWC-1 if you want to pursue a claim for a work related injury or illness. The district is self insured. Therefore, BUSD uses a third party administrator; who is responsible for making liability determinations regarding your claim. JT2 Integrated Resources (Third Party Administrator) determines liability using the available medical documentation and relevant facts.

Supervisor's Section: The supervisor must complete this section. Enter the date of the DWC-1 was sent to the employee by certified mail.

When the employee returns this form, forward it to:
Office of Risk Manangement
2020 Bonar Street, 2nd floor, Suite 234
Berkeley, Ca. 94704

EMPLOYEE'S ACKNOWLEDGMENT OF RECEIPT

This is to acknowledge that I have received a *Workers' Compensation Claim Form* (DWC 1) & *Notice of Potential Eligibility* (e 3301)

I understand that if I want to pursue a claim for a work-related injury or illness, it is my responsibility to complete the form and return it to my employer.

EMPLOYEE NAME	DATE OF INJURY OR ILLNESS
DATE CLAIM FORM RECEIVED	EMPLOYEE SIGNATURE ▶

EMPLOYER'S SECTION

Complete this section only if the employee is unavailable or refuses to sign this acknowledgment.

DATE CLAIM FORM PROVIDED TO EMPLOYEE OR SENT FIRST CLASS MAIL	SUPERVISOR'S SIGNATURE ▶